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ABSTRACT

Reducing the incidence and severity of child and adolescent injuries requires a multifaceted approach involving broad-based health and social service agencies, including schools. Recognition of the need for injury prevention education began with the Industrial Revolution in the 1900s, and safety education was developed as a unit of health instruction in the schools of the 1920s and 1930s. With the growing popularity of the automobile, concerns about traffic safety, pedestrian safety, and alcohol use and the automobile, brought about expansion of health education programs. Injury prevention and safety today are considered a content area of comprehensive school health instruction. Instruction should include attitudes toward safety, causes of accidents, home and school safety, traffic safety, fire prevention, survival education, environmental hazards, accident prevention, emergency health care, safety personnel, resources and agencies, individual safety precautions, recreational safety, occupational safety, safety rules, and laws and regulations. The content should be age-appropriate and should reflect the health problems of the nation, state, and local communities. State mandates concerning injury prevention instruction are noted, a list of barriers to effective injury prevention instruction is presented, and recommendations for program development are offered. (JDD)

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THE ROLE OF SCHOOL HEALTH INSTRUCTION IN PREVENTING INJURY: MAKING IT WORK.

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Abstract

Injury prevention has long been a unit of instruction in school health education. However, as with many units within a comprehensive school health instructional program, injury prevention has not received the attention it deserves for several reasons. Chief among them is society's perception that other health and social issues are more pressing, specifically substance abuse and problems associated with teenage sexual activity, including pregnancy and HIV infection. While these problems deserve the attention they receive, injuries remain the most significant health problem affecting the Nation's youth. Reducing the incidence and severity of child and adolescent injuries requires a multifaceted approach, involving broad-based health and social service agencies, including schools. This session is divided into four sections. The first section provides a historical perspective of injury prevention instruction in United States' schools. The second section provides an overview of what constitutes a comprehensive school health program, providing an outline of the physical structure of a "typical" injury prevention instructional unit. The third section examines the current status of injury prevention instruction within the framework of comprehensive school health education. The fourth section addresses the limitations of injury prevention instruction, providing a set of recommendations for future program development.

Introduction

Injury prevention has long been a unit of instruction in school health education. However, as with many units within a comprehensive school health instructional program, injury prevention has not received the attention it deserves for several reasons. Chief among them is society's perception that other health and social issues are more pressing, specifically substance abuse and problems associated with teenage sexual activity, including pregnancy and HIV infection. While these problems deserve the attention they receive, injuries remain the most significant health problem affecting the Nation's youth. Reducing the incidence and severity of child and adolescent injuries requires a multifaceted approach, involving broad-based health and social service agencies, including schools.

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I. Historical Perspective of Injury Prevention

Need Began With The Industrial Revolution (England) In The 1900's Concern For Safety Increased.

- 1913 National Safety Council Was Founded.
- 1917 First Comprehensive Safety Education Program.
- 1926 National Society For The Study of Education Devoted its 25th Yearbook to Safety Education.
- 1930s High School Drivers Education Began--Herbert J. Stack Introduced Classroom Instruction On Accident Prevention-- Amos Neyhart Organized The First Complete Drivers' Education Program Including Both Classroom and Laboratory Phases.
- 1940 American Assoc. of School Administration Devoted Its 1940 Yearbook to Safety Education.

Safety education as an unit of health instruction was a product of the "Safety Movement" of the 1920's and 1930's. Prior to the 1920's few programs of safety education were in the schools. Herbert J. Stack was a pioneer leader to both the "movement" in general and in the effort to place safety education into the health education curriculum.

Early safety education themes included "safety-first lessons" and developing "safety habits". In addition, the first laws relating to instruction in safety education had to do with specific topics such as fire prevention (fire drills), traffic safety and bicycle safety. In the 1930's safety demonstrations were popular and as result, safety education received increased attention.

Still, early safety education programs were far from meeting the needs of high school students in terms of the various types of accidents. The treatment of safety education topics in curricula and textbooks was light, inadequate, and narrowly focused on accident behavior.

The automobile-age also had a profound influence on school health instruction, especially drivers' education. With the ever growing popularity of the automobile, concerns about traffic safety, pedestrian safety, and alcohol and the automobile increased. As a result of the growth of drivers' education programs, health education programs expanded.

The state police, motor-vehicle departments also contributed to the expansion of safety education. In some states revenue generated from licensing or tags and in some instances fees from traffic fines were used to support safety education programs.

Currently, there is a renewed emphasis on personal safety, especially as it relates to unintentional and intentional injuries and their antecedent behaviors. Except for

some notable developments, however, the evolution of education for safety as a unit of health instruction in many ways parallels school health education. Future success of the former will depend on the latter.

II. What Constitutes Comprehensive School Health?

Comprehensive School Health Program is an organized set of policies, procedures, and activities designed to protect and promote the health and well-being of students and staff which has traditionally included health services, healthful school environment, and health education. It should also include, but not be limited to, guidance and counseling, physical education, food services, social work, psychological services, and employee health promotion.

School Health Education is one component of the comprehensive school health program which includes the development, delivery, and evaluation of a planned instruction program and other activities for students K-12, for parents and for school staff, and is designed to positively influence the health knowledge, attitudes, and skills of individuals.

Comprehensive School Health Instruction refers to the development, delivery and evaluation of a planned curriculum, K-12, with goals, objectives, content sequence, and specific classroom lessons which includes, but is not limited to the following major content areas:

- Community Health
- Consumer Health
- Environmental Health
- Family Life
- Mental & Emotional Health
- **Injury Prevention and Safety**
- Nutrition
- Personal Health
- Prevention and Control of Disease
- Substance Use and Abuse

Health Unit of Instruction is an ordered series of lessons organized around a major content area. Components of a health unit traditionally include goals or generalizations (conceptual statements), objectives, content, learning opportunities, and evaluation procedures.

Comment: The title given to a health unit should reflect the emphasis of the unit proper. Common titles used for the broad topic of safety include accident prevention and safety, injury prevention and safety, safety, safety and first aid, and safety and injury prevention. Whatever the title, it should be used consistently throughout the curriculum guide and include the instruction of "attitudes toward safety, causes of accidents, home and school safety, traffic (auto,

bicycle, school bus) safety, fire prevention, survival education, environmental hazards, accident prevention - potential hazards, first-aid and emergency health care, safety personnel, resources and agencies, individual safety precautions, recreational safety, occupational safety, safety rules, laws, regulations, and legislation."

In addition, when appropriate, instruction should include teaching about risk-taking behaviors associated with intentional injuries and those associated with unintentional injuries, resulting from accidents.

Comment: To be relevant and meaningful, the content of injury prevention and safety should be age-appropriate, that is, it should reflect the growth and developmental characteristics of children and youth, their health problems-as evidenced by epidemiologic data-health needs, interest and concerns. Content should also reflect the health problems of the nation, state, and local communities.

III. Status Of Injury Prevention Instruction.

- State Education Codes Or Other Legislation That Address School Health Education Exist in 45 States.

- Only 38 States Specifically Mandate School Health Instruction.

- Of The States That Require Specific Health Topics
  - 17 Require Safety Instruction
  - 9 Require CPR Instruction
  - 8 Require First Aid Instruction

- It Has Been Estimated That K-12 Students In The U.S. Are Required By States To Have An Average Of 14 Hours Of Health Instruction Each Year.

- 26 States Do Not Require Prospective Elementary School Teachers To Complete A Course In Health Education In Order To Meet State Certification Requirements.

IV. Limitations of Injury Prevention Instruction.

- Lack of instructional leadership & support.
  - state level (requirements)
  - local unit (political will)
  - school unit (district pressures)
  - parental & community support (apathy)

- Lack of qualified health teachers (7 - 12).
- Lack of adequately prepared elementary teachers.
- Lack of instructional time devoted to teach health.

- Lack of, or outdated, programs, curriculum materials and other instructional-related resources.
- Lack of systematic evaluation plans.
- Lack of focus on health education at the elementary level.
- Lack of confidence in health education as a "true" academic discipline.
- Lack of consideration for student abilities in scheduling health classes.
- Back to the basics' movement.
- Program Infidelity - failure of teachers to teach the intent of the designed course of instruction.
- Unrealistic expectations about the effectiveness of health education; health education is not a panacea for all societal ills.
- Content and process restrictions.

V. Recommendations For Program Development

Injury Prevention Initiatives Should:

1. Encourage state and local school boards to adopt a program of comprehensive school health education.

2. Support and provide technical assistance to state and local school districts in planning, implementing, and evaluating school health education programs.

3. Assist in the development of injury prevention units (K-12) that can be assimilated into existing health education curricula that can resist the test of time.

Efforts To Implement Injury Prevention Instruction Should:

4. Promote and strengthen existing school health programs.

5. Reflect the growth and developmental characteristics of children and youth, including social development, self-development, thinking-language development and physical development. In short, injury prevention instruction must be age-appropriate in terms of content presented and teaching methods utilized.

6. Reflect the health problems, and their antecedent behaviors and risk factors, of children and youth as evidenced by national, state, and local epidemiologic data.

7. Reflect the expressed needs, interests and concerns of children and youth.

8. Reflect the most advanced and accurate body of knowledge.

9. Reflect the Healthy People 2000 National Health Objectives for violent and abusive behavior and unintentional injuries.

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